**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FRWY SUITE 2200
HOUSTON TX 77356

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-05-6225-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This patient was admitted to Memorial Hermann Hospital through the ER due to major trauma. He suffered a finger amputation and subsequent surgical re-attachment." "The hospital submitted its complete medical bill in the amount of $39,354.75 on April 16, 2004, and my client received a partial payment of $6,170.00 on May 18, 2004." "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred. The carrier paid a total of $6,170.00 on this admit. Requestor is owed an additional $33,184.75, plus interest."

**Amount in Dispute:** $33,184.75

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "If the current hospital fee guideline is used as a benchmark to establish a fair and reasonable reimbursement that reimbursement would be $12,279.92, i.e. the Medicare base amount (Exhibit) derived from DRG 441 X 143%. The net fair and reasonable amount then would be $6,109.92, i.e. $12,279.92-$6,170.00." "Texas Mutual is willing to settle this dispute by paying an additional $6,109.22. If the requestor rejects that proposal and still demands 100% payment of its billed charges then Texas Mutual offers that the current hospital fee guideline MAR is a fair and reasonable payment and constitutes an appropriate reimbursement amount for the disputed services. "

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 6, 2004 through April 11, 2004 | Inpatient Services | $33,184.75 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on April 6, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 18, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated May 13, 2004
   - M-No MAR.
   - YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).

   Explanation of Benefits dated July 2, 2004
   - M-No MAR.
   - YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).
   - O-Denial after reconsideration.
   - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.

## Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 886.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred. The carrier paid a total of $6,170.00 on this admit. Requestor is owed an additional $33,184.75, plus interest."
   - The requestor did not discuss or explain how it determined that reimbursement of the entire amount billed would yield a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…"

22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | Date |
|---|---|---|

| Signature | Medical Fee Dispute Resolution Manager | Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.